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	495141	A. BUILDING _____ B. WING _____	C 10/08/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/06/15 through 10/08/15. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 105 certified bed facility was 100 at the time of the survey. The survey sample consisted of eighteen current resident reviews (Residents 1 through 17, and Resident 23) and five closed record reviews (Residents 18 through 22).	F 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of our agreement with the facts and conclusions set forth on the survey report. our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. RECEIVED OCT 23 2015 VDH/OLC	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, and resident interview the facility failed to ensure the location of the survey results report. No notice was posted of the availability or location of the most recent survey results.	F 167	F167 An additional survey binder was placed in the main hall intersection at wheelchair height during the survey on 10/7/15. All Residents have the potential to be affected. A sign stating the location to the original survey binder was located outside the administrator's office. Four (4) additional signs were posted throughout the facility directing people to both locations of the survey binder. The Social Worker reviewed the survey binder locations with the Resident council on 10/12/15. On or before 10/23/15 current Residents will be re-educated by the Social Worker on the location of the survey binders.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Kimberly D. Lawrence — Executive Director — 10/20/15

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F 167	Continued From page 1 Findings: Throughout the survey process conducted 10/6/15 through 10/8/15 general observations were performed. The most recent survey report book was located attached to the wall in the front lobby behind a receptionist desk with a small posted sign indicating title of survey report. A general observation tour was conducted on 10/7/15 at approximately 9:00 a.m. on all units, there were no obvious notices to residents or visitors indicating the whereabouts of the survey report book. On 10/7/15 at 2:30 p.m. this surveyor entered the "Game Room" located on "B" wing of the facility and began conversing with four of 9 resident's. During the conversation 4 resident's were asked the location of the "Survey Result Book." All four Resident's did not know the location of the book. The above finding was brought to the attention of the Administrator and Director of nursing on 10/7/15 at 4:00 p.m. No further information was given to the survey team prior to the exit conference on 10/8/15.	F 167	The Maintenance Director will check the location of binders on his morning rounds to ensure that the binders are in place. The Social Worker will poll the Resident Council weekly to ensure that no concerns exist as to the location of the survey binders. Any issues will be reported daily in standup with corrective action taken. The Executive Director will review any trends identified monthly with the QAPI committee for additional recommendations. Completion: 10/23/15	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241	F241 Resident #7 received a shower on 10/8/15 and her kardex was reviewed to ensure that her request for showers is honored. Current Residents will have their bath records for the prior 2 weeks reviewed by Nursing Administration to identify any trends of Residents not receiving baths as per their requested schedule.	

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F 241	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, facility staff failed to promote care in a dignified manner for one of 23 residents in the survey sample, Resident #7. Facility staff failed to promote care in a dignified manner for Resident #7 and to enhance her self-esteem and self-worth. Findings included: Resident #7 was originally admitted to the facility on 05/05/2015 and readmitted on 05/27/2015 with diagnoses including, but not limited to: Multiple Pressure Ulcers, Chronic PTSD (post traumatic stress disorder), Neurogenic Bladder, Myalgia, Incomplete Quadriplegia and Anemia. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 08/27/2015. Resident #7 was assessed as cognitively intact with a total cognitive score of 15 out of 15. On 10/07/2015 at approximately 9:05 a.m. this surveyor conducted an interview with Resident #7 in the privacy of her room. During this interview Resident #7 expressed many concerns to this surveyor regarding her care since being transferred to C-wing. Resident #7 stated, "On A-wing I got a bath everyday. I got more attention on A-wing." Resident #7 stated, "I have been on this wing since August. My Medicare ran out on A-wing, so I was moved here. My last shower was done by the therapy manager, (Name) and wound nurse, (Name). They put me in the	F 241	Current nursing staff to be re-educated by the DCE on or before 10/23/15 as to the requirements for bathing Residents per their request and facility policy and the definition of each type of bath, ie shower, whirlpool, full bed bath and partial bed bath. Management will review the prior days assignment sheets each morning during the start-up meeting to ensure that bathing occurred as required with immediate corrective action taken if needed. Medical Records will audit 3 charts per week to ensure that no bathing issues are missed in daily checks and provide trending to the QAPI committee monthly for 3 months to ensure compliance with this plan of correction. Completion: 10/27/15	

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shower chair." Resident #7 further stated, "My clothes are changed only after a shower and that isn't very often." This Resident voiced several times during our conversation, "I feel like I smell bad. My hands and legs are so bent up and I sweat so much. I just worry about smelling bad. It is demeaning. I feel like I have been put back a kid. Night shift is the worst. I had diarrhea one night and I called out at 7:30 and didn't get changed until 10:30. My bottom got red, excoriated."

At approximately 10:00 a.m. the clinical record for Resident #7 was reviewed. Resident #7 had a significant change MDS with an ARD of 06/03/2015. Section "F0400. Interview for Daily Preferences" revealed the following: All resident responses were coded as a "1" meaning "very important." "While you are in this facility... A. how important is it to you to choose what clothes to wear?...C. how important is it to you to choose between a tub bath, shower, bed bath, or sponge bath?..." Section "G0110. Activities of Daily Living (ADL) Assistance" revealed the following: "...G. Dressing...Self-Performance 3 (meaning extensive assistance), Support 3 (meaning Two+ {plus} persons physical assist)...J. Personal hygiene...Self-Performance 3, Support 3." Section "G0120. Bathing...A. Self-performance 4 (meaning total dependence), Support 3 (meaning Two+ {plus} persons physical assist."

Review of bath records for the months of August, September and October 2015 revealed the following:

8/01 - Partial (P) 9/01 - FBB 10/01 - S
8/02 - None 9/02 - P 10/02 -

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P

8/03 - P 9/03 - FBB 10/03 - P
8/04 - Shower (S) 9/04 - P 10/04 - P
8/05 - P 9/05 - P 10/05 - S
8/06 - P 9/06 - P 10/06 - P
8/07 - Full Bed Bath (FBB) 9/07 - S
8/08 - S 9/08 - P
8/09 - FBB 9/09 - P
8/10 - P 9/10 - FBB
8/11 - P 9/11 - P
8/12 - None 9/12 - P
8/13 - FBB 9/13 - P
8/14 - P 9/14 - S
8/15 - P 9/15 - P
8/16 - P 9/16 - P
8/17 - P 9/17 - FBB
8/18 - S 9/18 - P
8/19 - FBB 9/19 - P
8/20 - None 9/20 - S
8/21 - FBB 9/21 - P
8/22 - FBB 9/22 - P
8/23 - FBB 9/23 - P
8/24 - FBB 9/24 - S
8/25 - FBB 9/25 - P
8/26 - P 9/26 - P
8/27 - FBB 9/27 - P
8/28 - P 9/28 - FBB
8/29 - FBB 9/29 - P
8/30 - P 9/30 - P
8/31 - P

On 10/07/2015 at approximately 1:10 p.m. LPN #1 (licensed practical nurse) was interviewed regarding Resident #7 and her bathing preferences. LPN #1 is also the wound nurse. LPN #1 confirmed that she and the therapy director had showered Resident #7 in the shower

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chair last week and that Resident #7 prefers a shower in the chair. LPN #1 stated, "I think the aides are afraid to get her up in the shower chair. I spoke with one CNA (certified nursing assistant) regarding this and assured her the resident is steady in the chair. She is able to move a little. You have to remind her to relax. She can pull her left hand down with her right hand and can open her knees now." Regarding whether the CNA's are rushing this resident. LPN #1 stated, "I think they are just leery to move her because of her fragility, age and condition."

At approximately 2:00 p.m. the Therapy Director (Other #3) was interviewed regarding Resident #7. Other #3 stated, "She is getting PT (physical therapy) and OT (occupational therapy) five times a week. I asked for Restorative (RT) to continue for ROM (range of motion). If RT does the stretching, then PT/OT can focus on other areas of therapy instead of just stretching." Regarding Resident #7's personal care Other #3 stated, "I feel like her care was better on A-wing. I took her to the shower last week. You can tell she isn't bathed all the time because when we go in for stretching of her arms the creases are sweaty and have that yeasty smell."

RN #1 (registered nurse), Unit Manager of C-wing was interviewed at approximately 2:15 p.m. RN #1 stated, "A partial bath is basically a wash up, face, peri area, not a full bath." Regarding hands and mouth care RN #1 stated, "Yes hands and mouth care."

The Administrator and DON (director of nursing) were informed of the above information during a meeting with the survey team on 10/07/2015 at approximately 4:30 p.m. The DON stated she felt

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F 241	Continued From page 6 a partial bath was, "Washing the face, hands, arm pits and peri area. Oral care is separate." On 10/08/15 at approximately 8:00 a.m. this surveyor received copies of facility procedures for a "Bath, Partial" and "Bath, Bed." The "Bath, Partial Procedure # CLIN1300-170" included the following steps: "...PROCEDURE: ...7. Wash face and ears, and dry carefully...9. Wash, rinse and dry neck, arms and armpits well. 10. Wash, rinse and dry back, buttocks and genitals. (see perineal care procedure). 11. Care of fingernails is part of the bath...13. Comb and brush the resident's hair. 14. Apply lotion to skin as needed...18. Dress resident appropriately..." "Bath, Bed Procedure # CLIN1300-160" included the following steps: "PROCEDURE: ...7. Wash face and ears, rinse well and dry carefully....9. Wash neck, arms, chest and abdomen. Dry skin well. 10. Give special care to umbilicus, folds of skin, hands and feet. 11. Wash thighs, legs and feet...13. Wash back, buttocks, and genitals...14. Care of fingernails and toenails is part of the bath...16. Comb and brush the resident's hair. 17. Apply lotion to skin as needed...21. Dress resident appropriately..." No further information was received by the survey team prior to exit on 10/08/2015.	F 241		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248	F 248 The current activity calendar was reviewed with Resident #7 on 10/19/15 so she could articulate to the Social Worker what activities she would like to attend. Her activities assessment was also revised on 10/19/15.	

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F 248	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, facility staff failed to provide activities to meet the needs and preferences for one of 23 residents in the survey sample, Resident #7. Facility staff failed engage Resident #7 in activities to enhance her sense of well-being and to promote self-esteem and enhance her emotional health. Findings included: Resident #7 was originally admitted to the facility on 05/05/2015 and readmitted on 05/27/2015 with diagnoses including, but not limited to: Multiple Pressure Ulcers, Chronic PTSD (post traumatic stress disorder), Neurogenic Bladder, Myalgia, Incomplete Quadriplegia and Anemia. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 08/27/2015. Resident #7 was assessed as cognitively intact with a total cognitive score of 15 out of 15. On 10/07/2015 at approximately 9:05 a.m. this surveyor conducted an interview with Resident #7 in the privacy of her room. During this interview Resident #7 expressed concerns to this surveyor regarding lack of activities. Resident #7 stated, "I just lay back here in my room all day with nothing to do. I pray and think a lot. My husband comes to visit me. I haven't met the people in activities except for the new girl. She brought those	F 248	On or before 10/23/15, the prior 30 days of activity attendance will be reviewed for each Resident. Any Resident identified as potentially not having adequate participation will be reassessed and their care plan for activities revised. The Activity staff will be re-educated on or before 10/25/15 by the Executive Director as to the requirement for Residents to receive activities that meet their needs and interests. Current staff will be re-educated on this same requirement by the DCE on or before 10/25/15. The Executive Director/designee will review the monthly activity attendance logs at the close of each month and identify Residents whose attendance may signal a need to re-assess their activity plan of care and ensure that corrective action is taken.	

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F 248	Continued From page 8	F 248	The Executive Director/designee will trend for the QAPI committee each month the number of Residents identified as needing revised activity plans and what action was taken. The QAPI committee will make additional recommendations as needed. Completion: 10/25/15	

flowers hanging over there on the door." A small television was noted in this resident's room. Resident #7 stated, "Yes, that is my TV. I can see it sometimes, but rarely have it on because they don't turn it on and if it's on they don't like to change the channels. I try not to bother them because I know they are busy and have other people that need their help. I don't participate in activities because there is no one to take me. The only time I do anything is if therapy takes me. Therapy is the highlight of my day. They will wipe my face, put on chapstick, open my blinds if I ask them. They do anything I ask."

At approximately 10:00 a.m. the clinical record for Resident #7 was reviewed. Resident #7 had a significant change MDS with an ARD of 06/03/2015. Section "F0500. Interview for Activity Preferences" revealed the following: "While you are in this facility... A. how important is it to you to have books, newspapers, and magazines to read?" Coded as a "2" meaning "somewhat important. B. how important is it to you to listen to music you like?" Coded as a "1" meaning "very important"...D. how important is it to you to keep up with the news? E...do things with groups of people? F...do your favorite activities? G...go outside to get fresh air when the weather is good?" Questions D through G all were coded as a "2" meaning "somewhat important. H...participate in religious services or practices?" Coded as a "1" meaning "very important."

Resident #7's CCP (comprehensive care plan) included the following: "Focus - Sometimes I tire easily and prefer shorter or less active activities related to: Pain issues, cognitive decline. I like when my husband visits me, which is often. I

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enjoy listening to the tv and music in my room. I will be visited 1:1 (one on one) by activities as needed for sensory activities. Date initiated: 06/03/2015 Goal - I would like to be able to participate in the activities that are important to me over the next 90 days...Revision on: 08/31/2015 Target Date: 11/30/2015 Interventions - ...Continue to involve me in out of room activities as desired and able. If I desire, please assist me in contacting clergy or church for support. Offer me soothing activities as I desire. Hand massages, soothing music and conversation. Offer to read bible passages or other spiritual texts that are meaningful to me. Provide recreation materials for me to use independently or with family or hospice volunteer. Staff to provide life simple pleasures: coffee." No documentation was located in the clinical record to indicate any of these interventions had been performed with this Resident.

On 10/07/2015 at approximately 1:20 p.m. Other #2 (Activities Assistant) was interviewed regarding Resident #7. Other #2 stated, "I have been here about 30 days. I use a 'Care Plan Focus Summary' and a 'Kardex/Communication Form' to familiarize myself with the residents and their special needs. There isn't a specific activities plan written for each resident. We keep this binder with an activities calendar labeled for each resident. Whenever a resident attends, participates or refuses an activity the calendar is color coded using this guide: Yellow - attended, Blue - attended, but did not participate, Orange - behaviors during activity, Green - attended, left early, or wandered in and out of activity, Purple - resident refused 1:1 activity, No Color - did not attend." There was not an October activities calendar in the binder labeled for Resident #7.

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The September activities calendar for Resident #7 was marked "yellow" on Wednesday, 9/16/15 "room visit 4 pm" and Wednesday, 9/23/15 "room visit 4 pm." No other activities were marked on this resident's calendar for the month of September. Resident #7's 1:1 activity log included one notation dated 9/28/15, "1:1 Read Mail 5 min (minutes) Alert/Pleasant." Other #2 stated, "I know I saw her at least two other times in September. One visit we watched tv and another day we just talked. It looks like those sticky notes are missing. I was afraid that would happen." Other #2 stated, "I go to her room at least two times a week. There is no set plan for her. Her husband is here daily. A couple of weeks ago he was on vacation for a week and the nurse asked me to see her more often that week. I stick my head in often just to check on her and see if she needs anything." Regarding other employees in the Activities Department, Other #2 stated, "There is an Activities Director and another Activities Assistant. They both have gone back to school full time for their LPN (licensed practical nurse). They are only here on Friday afternoons, Saturday and Sunday of each week. I am here during the week, Monday through Friday. We all get together and talk on Friday afternoons."

The Administrator and DON (director of nursing) were informed of the above information during a meeting with the survey team on 10/07/2015 at approximately 4:30 p.m.

No further information was received by the survey team prior to the exit conference on 10/08/2015.

F 252 483.15(h)(1) F 252
SS=B SAFE/CLEAN/COMFORTABLE/HOMELIKE

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F 252	Continued From page 11 ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and resident interview the facility failed to ensure a homelike environment. The game room on "B" wing had a pool table in ill repair that included debris (pieces of paper and food particles), dried liquid (juice, coffee) stains, 5 of 15 balls, cue sticks with no tips. In addition, a television was in ill repair that included very low visibility picture quality and a crack in the screen. Findings: General observations were conducted on 10/7/15. At 8:30 a.m. this surveyor entered the "Game Room" located on "B" wing and observed a pool table with debris (pieces of paper and food particles) and dried liquid (juice, coffee) stains and only 5 of 15 balls. The cue sticks to play pool was also observed and evidenced no tips on the sticks (to allow the balls to be struck). At this time a large projection television (TV) was observed, the TV was turned on and had very low visibility of picture quality. There were three Resident's sitting in the game room at this time and was asked if they could see the TV. One of the three Resident's nodded his	F 252	F252 A new television was purchased and installed in the game room on 10/12/15. The pool table was removed and replaced with one from storage on 10/8/15. The balls were located in the facility and returned to the game room, having been moved by a resident. Additional pool cues/sticks and supplies were ordered on 10/8/15 and installed on 10/13/15. On or before 10/23/15, the Maintenance Director will complete an audit of the facility to identify any other potential non-homelike environment situations and take corrective action as needed. On or before 10/23/15, the DCE will educate current staff on the requirement for a homelike environment. Department managers will continue their daily rounds, with new focus on this requirement and concerns documented in the electronic maintenance tracking system.	

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F 252	Continued From page 12 head up and down and the other two verbalized they could see the TV but it was not clear and could not see the TV very well, and also verbalized there was a big crack in the screen of the TV. The crack was observed by the surveyor to be approximately 8 inches long. On 10/7/15 at 2:30 p.m. the activities assistant escorted this surveyor back to the game room on B wing and was asked her opinion of the pool table, the pool cues and the TV. The activities assistant verbalized she was aware of the condition of the pool table (indicating ill repair) and verbalized that no one can play pool with only 5 balls, verbalized unawareness of the condition of the pool cues (but did observe), and agreed that the TV had a large crack in the screen and picture quality was poor making it hard to see. During this time, there were 9 resident's in the game room, four of the resident's also verbalized (to this surveyor) the TV was hard to see and resident's could not play pool due to the condition of the pool cues and not enough balls The above finding was brought to the attention of the Administrator and Director of nursing on 10/7/15 at 4:00 p.m. The Administrator verbalized that the above findings had already been placed on a list sent to corporate for a 4th Quarter Capital Plan to be reviewed in order to be budgeted for new furnishings. No further information was given to the survey team prior to the exit conference on 10/8/15.	F 252	Reports from the electronic maintenance system will be reviewed monthly by the QAPI committee for trending and additional recommendations if needed. Completion: 10/23/15	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280	F280 Careplan regarding dental needs for Resident #2 was reviewed and updated by the MDS Coordinator on 10/8/15.	

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F 280	Continued From page 13 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and resident interview, the facility staff failed to review and revise the comprehensive care plan for one of 23 residents in the survey sample, Resident # 2. The facility staff failed to review and revise the CCP (comprehensive care plan) for Resident # 2 in the area of dental. Findings include: Resident # 2 was admitted to the facility on 12/04/13. Diagnoses for Resident # 2 included, but were not limited to: dementia, mood disorder,	F 280	The previous sixty days of nurses notes, SBARs, DQIs (incident reports), physicians order changes and 24 hour reports to be reviewed on or before 10/27/15 by nursing administration and cross referenced to the plans of care to ensure that all needed careplans revision have occurred, with corrective action taken as needed. Unit Managers and IDT members to be re-educated by the DNS/designee on or before 10/23/15 regarding the requirement to revise plans of care for all changes of conditions, including falls. Nurses notes, SBARs, DQIs, 24 hour reports and physicians order updates will be reviewed during the morning nurse's start-up meeting and cross-referenced to the care plan to ensure all	

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F 280	Continued From page 14	F 280	necessary updates have been made to the Resident plan of care. Any identified concerns will be logged on a corrective action log and provided to the Unit Manager and/or appropriate IDT team member for immediate corrective action and re-checked during the nurses' end of day meeting. DNS/designee will maintain the corrective action logs and present trending of any concerns at least quarterly to the QAPI committee so that the committee can monitor compliance with the plan and recommend any further action. Completion: 10/30/15	

alcohol dependence syndrome, anxiety disorder and hyponatremia.

The most current MDS (minimum data set) was an annual assessment dated 08/03/15. This MDS assessed the resident as having a cognitive score of "8", indicating the resident had moderate impairment in daily decision making skills. The resident was also coded on this MDS in Section L (Oral/Dental Status) as having "F. Mouth or facial pain, discomfort or difficulty with chewing."

During clinical record review on 10/06/15 and 10/07/15, it was documented that the resident had a weight loss of 12 pounds from July 3, 2015 to August 3, 2015.

Nursing notes for July and August were reviewed and documented that in the early part of August the resident was having some pain in the mouth around the gums. The nursing notes further documented that the resident was on the list to see the dentist.

The resident's CCP was reviewed and documented, "...Chewing difficulty as related to: edentulism. (says he has three teeth)...01/19/15 loose tooth left lower gum 08/03/15 gum pain-wt loss noted...dental consult PRN (as needed)...Oral inspection by licensed nurse..."

On 10/07/15 at approximately 3:00 p.m., the DON (director of nursing) and administrator were informed of the above information in a meeting with the survey team. The staff were made aware of concerns regarding the resident's weight loss related to the resident's complaining of mouth pain and that no documentation was found

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to evidence that a licensed nurse had completed any oral inspections of Resident # 2's mouth.

On 10/07/15 at approximately 3:30 p.m., the SW (Social Worker) informed this surveyor that the resident was seen by the dentist in April and did not have resources to see the dentist again, unless there was an emergent situation with the resident's teeth.

A dental consult dated 04/22/15 documented that the resident actually had "2" teeth (# 28 and # 29).

On 10/08/15 at approximately 9:45 a.m., the RD (Registered Dietitian) was interviewed and provided documentation regarding the resident's weight loss. The RD voiced that interventions were immediately put in place for the weight loss and that she did not know how many teeth the resident had and agreed that staff should know, if the resident was receiving oral inspections by a licensed nurse as indicted on the resident's CCP. The RD voiced speaking with the resident and the resident was currently denying pain in the mouth area.

On 10/08/15 at approximately 10:00 a.m., the resident was interviewed in his room. The resident was asked how many teeth he had and the resident voiced, two. The resident was asked if he was having pain in his mouth and voiced at this time he was not. The resident voiced that he had lost some weight and that his mouth had been sore "a while ago." The resident voiced that he would like to get dentures at some point. The resident was asked if he had his mouth checked out by anyone and the resident voiced that he had been to the dentist, but did not remember when.

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F 280	Continued From page 16 No further information or documentation was provided to evidence that Resident # 2's CCP was reviewed and revised to reflect the correct number of teeth the resident had or to evidence oral inspections were completed as indicated in the resident's CCP. No further information or documentation was presented prior to the exit conference on 10/08/15 at 10:30 a.m.	F 280		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, clinical record review and in the course of a complaint investigation, facility staff failed to provide care and services for two of 23 dependent residents in the survey sample, Resident #8 and Resident #7. 1. The facility staff failed to bathe Resident #8 per her preferences. Resident #8 prefers a bed bath due to fear of the whirlpool or shower. The unit manager, LPN #2 expects each resident to receive at least two full baths weekly and as needed. However, Resident #8 received only 2 full bed baths in August 2015 and only 4 for September 2015.	F 312	F312 Resident #7 received a shower on 10/8/15 and her kardex was reviewed to ensure that her request for showers is honored. Resident #8 received a full bed bath on 10/8/15 and her kardex was reviewed to ensure that she receives full bed baths as per her request. Current Residents will have their bath records for the prior 2 weeks reviewed by Nursing Administration to identify any trends of Residents not receiving baths as per their requested schedule.	

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F 312	Continued From page 17 2. Facility staff failed to ensure Resident #7 was bathed daily and per her preference. Findings included: 1. Facility staff failed to ensure Resident #8 received at least two full baths every week. Resident #8 was originally admitted to the facility on 07/08/2015 and readmitted on 09/30/2015 with diagnoses including, but not limited to: End Stage Renal Disease requiring Hemodialysis, Hypertension, Psychosis, Asthma, Diabetes and Schizophrenia. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 09/30/2015 was a five day readmission assessment. Resident #8 was assessed as moderately impaired in her cognitive skills with a total cognitive score of nine out of 15. Resident #8's clinical record was reviewed on 10/06/2015 at approximately 9:50 a.m. with special focus on bathing and hygiene. On 10/06/2015 at approximately 3:15 p.m. LPN #2 (licensed practical nurse) was interviewed regarding Resident #8 going to HD (hemodialysis) in soiled clothing and displaying an odor. LPN #2 stated, "She (Resident #8) used to refuse HD, wouldn't eat or do anything. She is much better now. She gets bed baths because she is afraid of the whirlpool bath and doesn't like the shower. She doesn't refuse baths or HD now. I know HD called here last week or a couple	F 312	Current nursing staff to be re-educated by the DCE on or before 10/23/15 as to the requirements for bathing Residents per their request and facility policy and the definition of each type of bath, ie shower, whirlpool, full bed bath and partial bed bath. Management will review the prior day's assignment sheets each morning during the start-up meeting to ensure that bathing occurred as required with immediate corrective action taken if needed. Medical Records will audit 3 charts per week to ensure that no bathing issues are missed in daily checks and provide trending to the QAPI committee monthly for 3 months to ensure compliance with this plan of correction. Completion: 10/27/15	

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weeks ago complaining she (Resident #8) had on the same outfit she had worn last time at dialysis. She did have on the same outfit, but it had been laundered. Laundry hangs clean clothes in the front of the closet and I don't have the same night shift staff here on Sunday and Tuesday nights. I have never detected an odor. It could be from her necrotic toes or from being uremic. Her levels are out there. She is really going down hill. That's why we accepted her back on hospice. She isn't going to get any better."

On 10/07/2015 at approximately 3:00 p.m. this surveyor reviewed the bath records for Resident #8 dated 08/05/2015 through 10/06/2015. Documentation revealed Resident #8 received the following baths on the dates below:
08/05/15 - 08/11/15 - Partial Bath (P)
08/12/15 - None
08/13/15 - 08/24/15 - P
08/25/15 - Full Bed Bath (F)
08/26/15 - 09/02/15 - P
09/03/15 - F
09/04/15 - 09/07/15 - P
09/08/15 - F
09/09/15 - 09/13/15 - P
09/14/15 - 09/16/15 - F
09/17/15 - 09/19/15 - P
09/20/15 - F
09/21/15 - 09/24/15 - P
09/25/15 - F
09/26/15 - P
09/27/15 - 09/30/15 - In Hospital
10/01/15 - P
10/02/15 - 10/03/15 - F
10/04/15 - P
10/05/15 - 10/06/15 - F

LPN #2 was interviewed on 10/07/2015 at

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approximately 3:35 p.m. on what exactly a Partial Bath included. LPN #2 stated, "Residents receive a partial bath every morning. It includes washing the face, under the arms (arm pits), peri area and under the breast area. The only difference from a full bath and partial bath is they get their hair washed on a full bath." LPN #2 was asked if the staff on her unit were aware of what she considered a partial bath. LPN #2 stated, "Yes."

At approximately 4:30 p.m. on 10/07/15 during a meeting with the survey team, the DON (director of nursing) defined a partial bath as, "Face, Hands, Arm Pits and Peri Area. Oral care is a separate area."

On 10/08/15 at approximately 8:00 a.m. this surveyor received copies of facility procedures for a "Bath, Partial" and "Bath, Bed." The "Bath, Partial Procedure # CLIN1300-170" included the following steps: "...PROCEDURE: ...7. Wash face and ears, and dry carefully...9. Wash, rinse and dry neck, arms and armpits well. 10. Wash, rinse and dry back, buttocks and genitals. (see perineal care procedure). 11. Care of fingernails is part of the bath...13. Comb and brush the resident's hair. 14. Apply lotion to skin as needed...18. Dress resident appropriately..."

"Bath, Bed Procedure # CLIN1300-160" included the following steps: "PROCEDURE: ...7. Wash face and ears, rinse well and dry carefully....9. Wash neck, arms, chest and abdomen. Dry skin well. 10. Give special care to umbilicus, folds of skin, hands and feet. 11. Wash thighs, legs and feet...13. Wash back, buttocks, and genitals...14. Care of fingernails and toenails is part of the bath...16. Comb and brush the resident's hair. 17. Apply lotion to skin as needed...21. Dress

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resident appropriately..."

The Administrator and DON (director of nursing) were informed of the above information during a meeting with the survey team on 10/07/15 at approximately 4:00 p.m. and again on 10/08/15 at approximately 10:00 a.m.

No further information was received by the survey team prior to the exit conference on 10/08/2015.

THIS IS A COMPLAINT DEFICIENCY.

2. Facility staff failed to ensure Resident #7 was bathed daily and per her preference.

Resident #7 was originally admitted to the facility on 05/05/2015 and readmitted on 05/27/2015 with diagnoses including, but not limited to: Multiple Pressure Ulcers, Chronic PTSD (post traumatic stress disorder), Neurogenic Bladder, Myalgia, Incomplete Quadriplegia and Anemia.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 08/27/2015. Resident #7 was assessed as cognitively intact with a total cognitive score of 15 out of 15.

On 10/07/2015 at approximately 9:05 a.m. this surveyor conducted an interview with Resident #7 in the privacy of her room. During this interview Resident #7 expressed to this surveyor her concerns about not being regularly bathed. Resident #7 stated, "On A-wing I got a bath everyday. I got more attention on A-wing." This Resident currently resides on C-wing. Resident #7 stated, "I have been on this wing since August.

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My Medicare ran out on A-wing, so I was moved here. My last shower was done by the therapy manager, (Name) and wound nurse, (Name). They put me in the shower chair." Resident #7 further stated, "My clothes are changed only after a shower and that isn't very often." This Resident voiced several times during our conversation, "I feel like I smell bad. My hands and legs are so bent up and I sweat so much. I just worry about smelling bad."

At approximately 10:00 a.m. the clinical record for Resident #7 was reviewed. Resident #7 had a significant change MDS with an ARD of 06/03/2015. Section "F0400. Interview for Daily Preferences" revealed the following: All resident responses were coded as a "1" meaning "very important." "While you are in this facility... A. how important is it to you to choose what clothes to wear?...C. how important is it to you to choose between a tub bath, shower, bed bath, or sponge bath?..." Section "G0110. Activities of Daily Living (ADL) Assistance" revealed the following: "...G. Dressing...Self-Performance 3 (meaning extensive assistance), Support 3 (meaning Two+ {plus} persons physical assist)...J. Personal hygiene...Self-Performance 3, Support 3." Section "G0120. Bathing...A. Self-performance 4 (meaning total dependence), Support 3 (meaning Two+ {plus} persons physical assist."

Review of bath records for the months of August, September and October 2015 revealed the following:

8/01 - Partial (P) 9/01 - FBB 10/01 - S
8/02 - None 9/02 - P 10/02 - P

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8/03 - P
9/03 - FBB
10/03 - P
8/04 - Shower (S)
9/04 - P
10/04 - P
8/05 - P
9/05 - P
10/05 - S
8/06 - P
9/06 - P
10/06 - P
8/07 - Full Bed Bath (FBB)
9/07 - S
8/08 - S
9/08 - P
8/09 - FBB
9/09 - P
8/10 - P
9/10 - FBB
8/11 - P
9/11 - P
8/12 - None
9/12 - P
8/13 - FBB
9/13 - P
8/14 - P
9/14 - S
8/15 - P
9/15 - P
8/16 - P
9/16 - P
8/17 - P
9/17 - FBB
8/18 - S
9/18 - P
8/19 - FBB
9/19 - P
8/20 - None
9/20 - S
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8/26 - P
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8/29 - FBB
9/29 - P
8/30 - P
9/30 - P
8/31 - P

On 10/07/2015 at approximately 1:10 p.m. LPN #1 (licensed practical nurse) was interviewed regarding Resident #7 and her bathing preferences. LPN #1 is also the wound nurse. LPN #1 confirmed that she and the therapy director had showered Resident #7 in the shower chair last week and that Resident #7 prefers a

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shower in the chair. LPN #1 stated, "I think the aides are afraid to get her up in the shower chair. I spoke with one CNA (certified nursing assistant) regarding this and assured her the resident is steady in the chair. She is able to move a little. You have to remind her to relax. She can pull her left hand down with her right hand and can open her knees now." Regarding whether the CNA's are rushing this resident. LPN #1 stated, "I think they are just leery to move her because of her fragility, age and condition."

At approximately 2:00 p.m. the Therapy Director (Other #3) was interviewed regarding Resident #7. Other #3 stated, "She is getting PT (physical therapy) and OT (occupational therapy) five times a week. I asked for Restorative (RT) to continue for ROM (range of motion). If RT does the stretching, then PT/OT can focus on other areas of therapy instead of just stretching." Regarding Resident #7's personal care Other #3 stated, "I feel like her care was better on A-wing. I took her to the shower last week. You can tell she isn't bathed all the time because when we go in for stretching of her arms the creases are sweaty and have that yeasty smell."

RN #1 (registered nurse), Unit Manager of C-wing was interviewed at approximately 2:15 p.m. RN #1 stated, "A partial bath is basically a wash up, face, peri area, not a full bath." Regarding hands and mouth care RN #1 stated, "Yes hands and mouth care."

The Administrator and DON (director of nursing) were informed of the above information during a meeting with the survey team on 10/07/2015 at approximately 4:30 p.m. The DON stated she felt a partial bath was, "Washing the face, hands, arm

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F 312	Continued From page 24 pits and peri area. Oral care is separate." See under Resident #8 above for procedures involved in a partial bath and a bed bath. No further information was received by the survey team prior to exit on 10/08/2015.	F 312		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to act upon a pharmacy recommendation for one of 23 residents in the survey sample: Resident # 15. The physician did not document the duration of/ reason for the continued use of an anti-fungal medication, and also failed to document clinical justification for refusing a GDR (gradual dose reduction) of an antipsychotic medication, Zyprexa. Findings include: Resident # 15 was admitted to the facility 3/30/10	F 428	F 428 The drug regime review for Resident number #15 will be re-reviewed with the attending physician on or before 10/23/15. The prior month's pharmacy reviews for current Residents will be audited by Nursing Administration on or before 10/23/15 for follow-up by the physician. Any identified as being incomplete will be presented to the current attending physician for completion on or before 10/30/15.	

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F 428	Continued From page 25 with diagnoses to include, but not limited to: unspecified intellectual disabilities, major depressive disorder, psychosis, dementia, hypothyroidism, convulsions, and GERD. The most recent MDS (minimum data set) was a quarterly review dated 8/16/15 had the resident coded as cognitively intact with a total summary score of 15 out of 15. The clinical record was reviewed 10/7/15 at approximately 11:30 a.m. Two pharmacy recommendations located in the clinical record did not have supporting documentation by the physician for the use of the medications. A pharmacy recommendation dated 8/2/15 documented "This resident is on Nystatin Powder since 7/20/15 and also Nystatin Cream since 4/2015. Please indicate below the duration of therapy or reasons for continual usage." The pharmacy recommendation form included several areas for the physician to check an option for the continuation or discontinuation of the medications. The physician did not address the available checked area's nor provide reason for continued usage. The physician signed the form, but did not date the signature, and handwritten on the form were two illegible words. LPN (licensed practical nurse) # 2 was at the nursing station during review and this surveyor asked for help in deciphering what the physician had written. LPN # 2 stated "I have no idea what that says; let me see if there's a progress note dictated that might have it printed." LPN # 2 then looked in the computer, and stated "No. There's nothing in here that would help." The second pharmacy recommendation was then reviewed. That recommendation was dated 9/24/15, and documented "Please consider changing the	F 428	Current licensed nursing staff to be re-educated on or before 10/23/15 by the DCE on the requirement for physician follow-up on all pharmacy recommendations. Going forward, each unit manager will be provided the recommendations for their wing by the pharmacy consultant at each visit. The unit manager will review the recommendation 1:1 with the physician on his/her next rounding date and ensure that a thorough response is documented prior to the recommendation being filed in the medical record. Medical records will audit 5 charts per months to ensure that pharmacy recommendations have adequate physician follow-up and report any trends or concerns to the QAPI committee monthly to ensure compliance with the plan of correction. Completion: 10/30/15	

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current order to Olanzapine (Zyprexa) to 7.5 mg once daily- may want to attempt trial dose reduction to 5 mg once daily at this time, if appropriate." It should be noted here Resident # 15 had been receiving Zyprexa 2.5 mg every morning, and 5 mg at bedtime since 8/27/14. The physician put an "X" in the box on the recommendation form which documented "Rejected: Please continue current orders and document clinical rationale below: (Rejected recommendations should include supporting documentation as to the rationale for continuing current therapy)." The physician signed the form, but did not date the form nor provide requested documentation for the rejection of the recommendation. Below the physician signature was handwritten "leave as is." LPN # 2 was at the nurses' station during the review, and was asked about the recommendation. LPN # 2 stated "Well, where he wrote 'leave as is' on there is his rationale. We've always had a time with that doctor about not documenting the rationale."

The above findings were shared with the administrator and DON (director of nursing) during an end of the day meeting 10/7/15 beginning at 4:00 p.m. The DON was asked who reviewed the pharmacy recommendations to ensure a clinical justification was documented by the physician. The DON stated "The unit manager gets the form back if there are any orders or changes; then it goes to medical records to be filed on the record."

No further information was provided prior to the exit conference.

F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review, the facility staff failed to ensure

The locked boxes inside the refrigerator on B-wing and C-wing were affixed permanently to the refrigerator with brackets by the Maintenance Director on 10/9/15.

All residents with medication stored in the locked refrigerator boxes have the potential to be affected.
The locked box inside the refrigerator on A-wing was also affixed permanently to the refrigerator by the Maintenance Director on 10/9/15. No other refrigerator lock boxes exist.

A column was added to the refrigerator temperature log for documenting that during the daily check of the refrigerator that it is confirmed that the locked box is affixed to the refrigerator.
Current staff to be re-educated on or before 10/23/15 by the DCE as to the requirement for controlled substances subject to abuse to be stored in a permanently affixed compartment.
Licensed nurses to also be educated on the new process of documenting the checking of the locked box.

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F 431	Continued From page 28 controlled substance medications (subject to abuse) were in a separately locked, permanently affixed compartment on two of three medication rooms in the facility (B- wing and C- wing). The facility staff failed to ensure 14 vials of Ativan were in a locked, permanently affixed compartment on the B-wing and failed to ensure 40 vials of Ativan and one (30 milliliter) bottle of oral Ativan was in a locked, permanently affixed compartment on the C-wing. Findings include: On 10/07/15 at 7:30 a.m., the B-wing medication room was observed with LPN (Licensed Practical Nurse) # 5. LPN # 5 unlocked the main door to the medication room with a key; once inside the medication room, the LPN was asked to unlock the refrigerator. The LPN voiced that there were narcotics inside. LPN # 4 unlocked the refrigerator with a key. The refrigerator had a small black box, which was locked (not permanently affixed). LPN # 5 removed the box from the refrigerator and sat it on the counter and opened it up with a key. The black box contained 14 vials of injectable Ativan. The injectable vials were all unopened. The LPN was asked if this is how this medication was normally stored and the LPN stated, "Yes." The LPN was asked if she knew that the medication was suppose to be stored in a permanently affixed, locked compartment. The LPN voiced, "No."	F 431	The daily refrigerator check logs will be presented to the QAPI committee monthly for trending and tracking of any identified concerns with corrective action taken if needed. Completion: 10/23/15	

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A facility policy was requested from LPN # 5 at that time.

At approximately 7:45 a.m., the C -wing medication room was observed with LPN # 6. LPN # 6 was asked to unlock the refrigerator. The lock on the outside of the refrigerator was loose (the screw attached to the refrigerator door was not completely screwed into the door and was not secure to touch). Inside the refrigerator was a small black box with a lock, the LPN was asked to open the box. LPN # 6 removed the box from the refrigerator, sat it on the counter and unlocked the box with a key. Inside the box were 40 vials of Ativan (all unopened) and one (30 milliliter) bottle of liquid (oral) Ativan inside. The oral Ativan had been opened and partially used. The LPN was asked if this is how narcotics are stored and the LPN voiced, yes. The LPN voiced that she did know that the box was suppose to be permanently affixed and voiced that staff normally take the box out and carry it to another location for counting and tracking.

The administrator and DON (director of nursing) were made aware of the above findings in a meeting with the survey team on 10/07/15 at approximately 10:40 a.m. The DON and administrator both voiced that they did not think that the locked box had to be permanently affixed. A policy on medication storage was requested for the second time, at this time.

Information was presented and reviewed on 10/08/15 at approximately 7:40 a.m., regarding medication storage. The information was typed on two sheets of paper. The documentation had no policy name, no review date, no pharmacy information and no data to indicate that the

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F 431	Continued From page 30 information was an actual policy. At approximately 8:50 a.m., a policy on drug/medication storage was requested again. At approximately 9:15 a.m., a policy was presented and reviewed. The policy titled, "Medication Storage in the Facility Controlled Substance Storage" documented, "...Schedule II-V medications and other medications subject to abuse or diversion are stored in a permanently affixed, double locked compartment separate from all other medications...Controlled substances that require refrigeration are stored within a locked box within the refrigerator. This box must be attached to the inside of the refrigerator..." No further information or documentation was provided prior to the exit conference on 10/08/15 at 10:30 a.m.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	F441 LPN #3 was re-educated on medication pass procedure including handwashing procedures on 10/12/15 by the DCE. Current licensed nurses to be assessed for medication pass/handwashing competency on or before 10/27/15 by the DCE/designee with additional training provided if needed.	

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F 441	Continued From page 31 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, staff interview and facility document review the facility staff failed to follow infection control practices for handwashing. Findings include: On 10/6/15 beginning at 2:10 p.m. a medication pass and pour observation was conducted with LPN (licensed practical nurse) # 3. LPN # 3 was preparing medications for administration, but stated "I don't think the resident is in her room; let me check." LPN # 3 went to the resident's room	F 441	Current licensed nurses will complete a monthly medication pass to include demonstration of proper handwashing technique in front of a member of Nursing Administration for the next 3 months. Additional training will be provided if needed. Current staff will be re-educated by the DCE on the handwashing policy by the DCE on or before 10/27/15. The DNS/designee will report trends of the monthly medication pass demonstrations to QAPI each month for 3 months with the committee recommending additional corrective action if needed. Completion: 10/27/15	

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F 441	Continued From page 32 and stated "No, she's not in there." LPN # 3 then put the medication back in the med cart, and began preparing another resident's medications. LPN # 3 crushed the medication, went to the unit snack room for ice cream to put the medication in, put the ice cream and medication in a medication cup and administered it to the resident. LPN # 3 returned to the medication cart and recorded the medication on the electronic administration record. LPN # 3 was not observed to wash her hands between any of the activities of pulling medications, preparing medications, administering medications, or prior to exiting the resident's room. This surveyor informed LPN # 3 of the observation, and LPN # 3 stated "And I had hand sanitizer right on the med cart." The hand washing policy was requested from LPN # 2 10/6/15 at 2:45 p.m. The policy "Bloodborne Pathogens Exposure Control Plan-Handwashing" was then reviewed. Under "When to Wash Hands" was documented "..... Before preparing medication pass.....Before and after all patient/resident care activities." On 10/7/15 during a meeting with facility staff beginning at 10:45 a.m. the administrator and DON (director of nursing) were informed of the above observation. No further information was provided prior to the exit conference.	F 441	F502 An order was obtained from the attending physician to obtain the lab on Resident #3 on 10/9/15. An Audit of lab orders for all Residents to be completed on or before 10/23/15 by Unit Mangers with any corrective action to be taken immediately.	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness	F 502		

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F 502	Conlinued From page 33 of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to obtain a physician ordered lab for one of 23 residents in the survey sample: Resident # 3. A CMP (comprehensive metabolic panel) was ordered by the physician 9/14/15 was not obtained. Findings include: Resident # 3 was admitted to the facility 5/2/12 with diagnoses including but not limited to: end stage dementia, high blood pressure, chronic airway obstruction, and epilepsy/convulsions. The most recent MDS (minimum data set) was a quarterly review dated 8/20/15. Resident # 3 was coded as having short term and long term memory problems, and moderately impaired in decision making skills. During review of the clinical record 10/6/15 at 10:45 a.m. it was noted a physician order dated 9/14/15 for "CBC (complete blood count) and CMP Q (every) 12 months." Further review of the clinical record failed to reveal a result for the CMP. On 10/7/15 during a meeting with facility staff beginning at 10:45 a.m. the administrator and DON (director of nursing) were informed of the above findings. The DON stated "We'll see what we can find out; it may not have been put on the chart yet."	F 502	All Nurses to be re-educated on or before 10/23/15 as to the need to monitor consultant reports, lab reports, 24 hour reports and physicians order sheets for new lab orders. During the daily nursing start-up meeting, Nursing Administration will print the prior day's nurses' notes and physician orders for review along with the 24-hr report to identify new lab orders. These orders are then noted on a Lab Tracking Form which will be utilized in future start-up meetings to ensure completion of the labs and receipt of results. The Lab Tracking Form will be taken weekly to the Clinical Committee Meetings for trending and additional corrective action if required with notation in the committee minutes. Committee minutes will be submitted to QAPI monthly for additional monitoring compliance and additional recommendations. Completion: 10/27/15	

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F 502	Continued From page 34 On 10/7/15 at 2:00 p.m. RN (registered nurse) # 1 told this surveyor "The CMP wasn't done; we just got a verbal order to get the lab tomorrow." On 10/8/15 at approximately 8:30 a.m. LPN (licensed practical nurse) # 2 gave this surveyor a copy of a form indicating the lab had been drawn. No further information was provided prior to the exit conference.	F 502		